Department of HUMAN SERVICES

Health Home Learning Collaborative

Assessment Process

June 21, 2021

Logistics

- Mute your line
- Do not put us on hold
- We expect attendance and engagement
- Type questions in the chat as you think of them and we will address them at the end.

This Training is a Collaborative Effort Between the Managed Care Organizations and Iowa Medicaid Enterprise

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AGENDA

1. Target Population for CCHH Services.....Emma Badgley, AGP
2. Engaging Members……Emma Badgley, AGP
3. Assessment……Emma Badgley, AGP
4. Member Retention……..Emma Badgley, AGP
5. Risk Stratification……Emma Badgley, AGP

Upcoming Topics:

July 19	**Incorporating Specialist's plan of care with the Health Home Plan of care.**	**ITC**
Aug 23	Person-centered planning Philosophy	ITC
Sept 29	All day • Agenda TBD	All

Learning Objectives

- Review the assessment process
- Discuss engaging members in CCHH and mental health/physical health services
- Discuss strategies for member retention, i.e. Motivational Interviewing
- Review the benefits of risk stratification

Knowing The Target Population

BENEFITS OF THE CHRONIC CONDITION HEALTH HOME

Target Population

- Minimum eligibility criteria
  - Two chronic health conditions or one chronic health condition and the risk of developing a second.
- The gap between eligibility and those who can benefit most

Basics

- Population health management begins by:
  - Developing a strategic road map (i.e. policy and procedures)
  - Gathering key demographic and clinical data about patients which may also include calculating a risk score or assigning a risk category
  - Sorting patients into categories using their risk score (risk stratification) to determine the right care at the right time which also includes preventative care / gaps in care

Basics, cont'd

- Analyzing the population further to address specific health issues (e.g. diabetes, heart disease, smoking, obesity)
- Employing evidence based practices including referrals to evidence based programs
- Collecting feedback on workflows and patient satisfaction
- Measure outcomes

The use of Motivational Interviewing

ENGAGING MEMBERS

Motivational Interviewing

- Motivational Interviewing (MI) is often recommended as an evidence-based approach to behavior change.
- Definitions do vary widely
  - What is MI, and what it isn't
  - Where to go next for more learning

Motivational Interviewing

- Key qualities include:
  - MI is a **guiding** style of communication, that sits between **following** (good listening) and **directing** (giving information and advice)
  - MI is designed to **empower** people to change by drawing out their own meaning, importance and capacity for change
  - MI is based on a **respectful** and **curious** way of being with people that facilities the natural process of change and honors client autonomy

Motivational Interviewing

- While the principles and skills of MI are useful in a wide range of conversations, MI is particularly useful to help people examine their situation and options when any of the following are present:
  - Ambivalence is high
  - Confidence is low
  - Desire is low
  - Importance is low

Core Principles

- MI is practiced with a **spirit** or way of being with people:
  - Partnership
  - Evocation
  - Acceptance
  - Compassion

Core Principles

- MI has core skills of OARS, attending to the language and the artful exchange of information:
  - Open Questions
  - Affirmation
  - Reflections
  - Summarizing
  - Attending to the language of change
  - Exchange of information

MI Processes

- MI has four fundamental **processes**. These processes describe the flow of the conversation although we may move back and forth among them as needed:
  - Engaging
  - Focusing
  - Evoking
  - Planning

Benefits of MI

- Method of communication vs. an intervention
- Benefits:
  - Applied to a broad range of settings
  - Compares well to other evidence-based approaches
  - Compatible with the values of many disciplines (Person-Centered Planning)
  - Principles are intuitive or “common sense”

Strategies for continued engagement

MEMBER RETENTION

Enhancing Member Retention

- Build patient loyalty
  - Patient Surveys/questionnaires
    - Showing patients that their opinion matter is a great way to build trust. Taking the opinions and implementing them are an even greater way to build trust
  - Engaging patients at strategic times throughout the year

Enhancing Member Retention

- Provide Education
  - Educational campaigns help build trust and confidence, for both potential health home enrollees and current ones
  - You cannot forget your patient audience when developing pieces of educational collateral, and you don't want the patient looking elsewhere for this information if you don't actively communicate with them

Enhancing Member Retention

- Be Responsive
  - Respond in a timely manner
  - Listen to your patients
- It's never too early or late to think about member retention. Whether you're a clinic part of a larger health system or a small rural provider, your patients are your advocates and the more you concentrate on them, the more likely you are to *keep* them

ASSESSMENT

Health Home Role

- Comprehensive Care Management includes assessment of various aspects, and is the responsibility of the Designated Practitioner role within the CCHH.
  - The Nurse Care Coordinator may assist with comprehensive care management.

Comprehensive Assessment

- The review of current functioning of the individual using the service in regard to the individual's situation, needs, strengths, abilities, desires, and goals.
- A holistic, comprehensive assessment begins the process of identify not only the needs of the member, but also what they believe is important to them.

Comprehensive Assessment

- Acts as a guide for the care plan
- Completed annually and as needed
- Comprehensive
  - Behavioral health
  - Physical health
  - Dental
  - Education / employment
  - Transportation
  - Housing
  - Social (spiritual, culture, economics, etc.)
  - Safety
  - Individual / family strengths and resources
  - Natural supports

Risk Assessment

- SBIRT annually for 18 years and older
  - DAST for drug assessment
  - AUDIT for alcohol assessment
  - Brief intervention by CADC or referral for treatment
- AHA/ACC-ASCVD Risk Estimator calculator
  - Annual visits
  - Disease Management template
- Framingham Risk Calculator
  - Annual visits
  - Disease Management template

Risk Assessment

- Sexual Risk Assessment
  - annual female visit
  - not a good assessment for males
  - Behavioral Health to assess

Risk Assessment

- Depression
  - PHQ2
    - Annually 12 years and older
    - If positive, PHQ9 done
  - PHQ 9
    - Behavioral Health referral
    - Behavioral Health assess with patient permission at time of visit
  - Fall Risk
    - Medicare annual wellness visits

Prioritizing your population

RISK STRATIFICATION

The Need for Risk Stratification

- Predict risks- proactively identify patients at risk of unplanned hospital admissions, etc
- Individualized care plans- identifying patient-specific risk factors to tailor a care plan to their needs
- Understanding trends- providers can better understand their patient population

Risk Stratification Models

- Many electronic health records (EHRs) have built in risk stratification capabilities
- The risk stratification tool you use depends on what you are trying to accomplish (SPA / larger agency and community goals) and how feedback loops and data are used for adjustments

Risk Stratification Models, cont'd

- Hierarchical Condition Categories (HCCs)
  - Designed as part of the Medicare Advantage Program by CMS.
  - Incorporates 70 conditions
- Adjusted Clinical Groups (ACG)
  - Developed by John Hopkins University
  - Uses inpatient and outpatient diagnoses and predicts hospital utilization

Risk Stratification Models, cont'd

- Chronic Comorbidity Count (CCC)
  - Total count of selected comorbid conditions over six categories
  - Uses public data from the Agency for Healthcare Research and Quality
- Daily Living Activities-20 (DLA-20)
  - 30 day snap shot of 20 domains and a summary of strengths and needs
  - Copyrighted tool, initial 3.5 hour training

Risk Stratification Models, cont'd

- A Level of Care Utilization System (LOCUS)
  - Determines the resource intensity needs of individuals who receive adult mental health services.
- Patient Tier Assessment Tool (PTAT)
  - Uses expanded diagnostic clusters (EDC)
  - Identifies the complexity of a patient and tier

Risk Stratification Models, cont'd

- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
  - National effort
  - Collects data needed to better understand patients' social determinants of health
  - Data from PRAPARE is updated in EHR and combined with data from other clinic systems
- Your own / Magellan

Thank you!